KR-300
Rev. 7/97

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH SERVICES
Department for Public Health

Instructions
Print in ink or type.
Answer each item completely and accurately. Incomplete answers may result in delay of your certification.

RADIATION OPERATOR CERTIFICATION
DIAGNOSTIC X-RAY APPLICATION FORM

FOR DEPT. USE ONLY
DO NOT WRITE IN THIS SPACE

_____

_____

I. PERSONAL INFORMATION

Date of Birth: _____
Month Day Year

Social Security Number: ☐☐☐ ☐☐ ☐☐☐☐

_____
Telephone Number

NAME: _____
(Last) (First) (Middle)

MAILING ADDRESS: _____
(Street, RFD, or Box No.)

_____
(City) (State) (Zip Code)

II. EMPLOYMENT INFORMATION

_____
Telephone Number

A. Place of Employment (Name): _____

B. Business Address: _____
(Street, RFD, or Box No.)

_____
(City) (State) (Zip Code)

C. Where are you employed? (Check appropriate box)

☐ Hospital ☐ Clinic ☐ Mobile Health Service
☐ Private Office ☐ Unemployed
☐ County Health Department ☐ Industry ☐ Other _____

D. Are any radiographic examinations, utilizing contrast media (e.g. gall bladder, GI series, IVP, etc.) performed at your place of employment? ☐ yes ☐ no

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III. EDUCATION INFORMATION

A. Have you graduated from High School? (Check appropriate box) ☐ yes ☐ no
If "Yes", year of graduation _____

B. Have you passed a High School Equivalency Test (GED)?
(Check appropriate box) ☐ yes ☐ no

If "Yes", give:
(1) Equivalency Certificate Number: _____ Date: _____

C. Indicate the type of teaching facility where you received your training as a radiation operator. (Check appropriate box)

☐ Hospital
☐ Junior/Community College
☐ Military
☐ Vocation/Technical School
☐ University
☐ Other _____

D. Name and address of the teaching facility at which you received your radiologic technology training:

_____
(Name of teaching facility)

_____
(Address) (City) (State) (Zip Code)

Date of Graduation: _____

NOTE: If you are not certified by a national registry but have completed a two year training program, documented evidence must be submitted attesting to your satisfactory completion of the training program. This evidence must be a letter from the Director of the training program or must be a copy of your certificate or diploma. (Do not send an original certificate or diploma)

E. Have you received a degree from a college/university? (Check appropriate box) ☐ yes ☐ no

If "Yes", check the appropriate box for the highest degree received:

☐ AA/AS ☐ BA/BS ☐ MA/MS ☐ D.SC/Ph.D.

IV. PROFESSIONAL AFFILIATION

A. Are you certified by The American Registry of Radiologic Technologist (ARRT) or its equivalent? (Check appropriate box) ☐ yes ☐ no

B. If "Yes", submit a copy of the ARRT registry certificate.

V. GENERAL

A. Fees:

1. Registration fee (non-refundable) $25.00

2. Certification fees:
   a. General Certificate 35.00
   b. Limited Certificate 35.00
      (General and Limited Certificates renewed biennially)
   c. Temporary certificate (Valid for one year - Not renewable) 25.00
   d. Provisional (Valid for one year - Not Renewable) 25.00

3. Payment of fees:
   Please pay the Registration Fee in addition to one Certificate Fee. All fees submitted relative to certification must be in the form of a check or money order, made payable to: "Kentucky State Treasurer".

NOTE: Should certification be denied because of failure to comply with the Kentucky Revised Statues or the regulations pursuant thereto, only the certification fee will be refunded.

B. Have you previously applied for Kentucky radiation operator certification?
(Check appropriate box) ☐ yes ☐ no

If "Yes", When _____

Under what name _____

VI. SIGNATURE/DATE

All applicants please read and sign/date the statement below. All applications will be null and void unless properly signed and dated.

I declare, subject to the penalties for perjury, that the statements made herein and on accompanying papers have been examined by me and to the best of my knowledge and belief are true and correct. I further understand that a false statement knowingly made by me may be cause for denial, revocation or suspension of any certificate pursuant to this application and for criminal prosecution and punishment.

_____ _____

(Signature of Applicant) (Date)

MAIL APPLICATION FORM AND APPROPRIATE FEE TO:

Radiation Operator Certification Program
Department for Public Health
HS2E-D
275 East Main St
Frankfort KY 40621